



## FIELDWORK EXPERIENCE VERIFICATION FORM UNDERGRADUATE CLINICAL EXPERIENCE

**INSTRUCTIONS:** COMPLETE ALL SECTIONS OF THE FORM AND SEND TO COLLEGE OR UNIVERSITY FOR VERIFICATION BY CURRENT TRAINING PROGRAM DIRECTOR/COORDINATOR. PLEASE PRINT IN BLUE INK OR TYPE. ALL SIGNATURES MUST BE IN BLUE INK.

APPLICANT'S NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

UNIVERSITY OR COLLEGE: \_\_\_\_\_

Location Where Experience Was Obtained	Dates of Experience		Total Hours Earned
	From (Mo/Yr)	To (Mo/Yr)	

**TOTAL:**

I certify that all fieldwork experiences listed on this form were completed according to the State of California requirements. I further certify under penalty of perjury under the laws of the State of California that all statements made herein are true in every respect.

\_\_\_\_\_  
 Signature of Applicant (Blue ink)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Training Program Director (Blue Ink)

\_\_\_\_\_  
 Date